Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN0601	A. BUILDING _____ B. WING _____	10/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADLEY HEALTH CARE & REHAB	2910 PEERLESS RD CLEVELAND, TN 37312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments During the annual licensure survey conducted on October 18 - 24, 2011 the facility was cited a Type "A" penalty for failure to be administered in a manner to ensure an effective system was in place to ensure injuries of unknown origin were thoroughly investigated, resulting in an injury of unknown origin not being thoroughly investigated or reported to the state for one (#12) resident, failed to ensure the supervision and safe use of a wheelchair for one (#15) resident from harming self and others, and failed to ensure social services were provided for residents (#12, #15, #27, #30) with behaviors for forty-nine residents reviewed which placed resident #12, #15, #27, & #30 in an environment which was detrimental to health, safety and welfare. Complaint investigation #27684, #27758, and #27833, were completed during the annual licensure survey. No deficiencies were cited related to the complaint investigations under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		
N 401	1200-8-6-.04(1) Administration (1) The nursing home shall have a full-time (working at least 32 hours per week) administrator licensed in Tennessee, who shall not function as the director of nursing. Any change of administrators shall be reported in writing to the department within fifteen (15) days. The administrator shall designate in writing an individual to act in his/her absence in order to provide the nursing home with administrative direction at all times. The administrator shall assure the provision of appropriate fiscal resources and personnel required to meet the needs of the residents.	N 401	N401 A. Resident #12-Discovered bruise on July 22, 2011. Clinical manager reviewed accounts July 25, 2011 given by nurse and CNA on duty during initial discover. ADON reviewed account on July 25, 2011. Reopened investigation 10/28/11. ADON re-interviewed nurses and CNA's on duty during initial discovery. Investigation was completed 11/1/11. No other action was required. No intentional injury occurred based on resident behavior	11/08/1

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N 401	Continued From page 1 This Rule is not met as evidenced by: Based on observation, medical record review, facility policy review, and interview, the facility failed to be administered in a manner to ensure an effective system was in place to make sure injuries of unknown origin were thoroughly investigated, resulting in an injury of unknown origin not being thoroughly investigated for one (#12) resident, failed to ensure the supervision and safe use of a wheelchair for one (#15) resident from harming self and others, and failed to ensure social services were provided for residents (#12, #15, #27, #30) with behaviors for forty-nine residents reviewed which placed resident #12, #15, #27, & #30 in an environment that was detrimental to their health, safety and welfare. The findings included: During interview with the Administrator on October 21, 2011, at 9:10 a.m., in the conference room, revealed the following: The Administrator agreed injuries of unknown origin, including injury around the genital area, would require a thorough investigation with the Medical Director, nursing, social services, and the Abuse Coordinator involved. The Administrator stated the Licensed Clinical Social Worker (LCSW) was the Abuse Coordinator and upon further questioning (specific to the LCSW's interview of October 20, 2011, when the LCSW stated, I am not the designated Abuse Coordinator) the Administrator	N 401	and reaction to others was unchanged, no further incident of this type has recurred. Abuse coordinator reviewed all documentation on 11/1/11 of investigation and no abuse was substantiated per clinical assessment. The medical director was notified by DON on October 25, 2011. NP was notified by DON on October 28, 2011. Medical director & NP were notified of investigation completion on 11/8/11 by DON. No further orders were given. State guardian was notified 11/1/11. In-servicing on abuse policy, unknown origin, and behavior management policy began on 10/28/11 and all staff were in-serviced by 11/7/11 unless on vacation or leave and they will be in-serviced on date of return to work. All agency staff will be in-serviced prior to work. Revised abuse policy on November 6, 2011 was combining unknown injuries/accident incidents to be included in policy. No new information was added. State was notified of incident & investigation through IRS system on 11/7/11. Resident #12 has had a behavior component added to her Care Plan 10/28/11 by social service assistant assigned to that resident. After SS director (LCSW) assessed resident, on 10/28/11 an individualized written behavior management plan was formulated, and then SS director in-	

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N 401	Continued From page 2 stated, "...maybe she isn't the Coordinator, ..I'm not sure it is in writing...maybe that is a weak area." The Administrator verified the nursing staff members involved in assessing the injury of unknown origin for resident #12 did not have the education and training necessary to determine if assult could be ruled out. During the interview, the Administrator stated, "I'm not the guy to tell you we were 100%..." The Administrator verified there were no questions or discussions related to the injury of unknown origin for resident #12 with the Administrator prior to October 20, 2011, "Yesterday (October 20, 2011) I talked to the wound care nurses...people did check her ...documentation is not 100%..." The Administrator confirmed the Medical Director was not informed of the injury of unknown origin for resident #12. When the Administrator was asked about resident #15's unsafe behaviors with wheelchair and whether aware resident #27 had an altercation with resident #15 and resident #30 had hit resident #12 in the face, the Administrator responded, "I can't possibly know about all the behaviors...I knew about 2 or 3...I wasn't aware of what (resident #15) was doing with...wheelchair." Continued interview confirmed the facility did not have a behavior management program and stated, "we are working on it right now..."	N 401	serviced nursing staff on plan and placed plan in chart on 10/28/11 and also copy of plan placed in Behavior Sheets book at nurses station. Resident #15 has had a behavior component added to his care plan 10/27/11 by social services assistant assigned to that resident. After social service director (LCSW) assessed resident, on 10/27/11an individualized written behavior management plan was formulated and then social service director in-serviced nursing staff on plan and placed plan in chart on 10/28/11. One on one was already in place and continued until out to hospital for unrelated medical issues on 11/3/11. Resident #27 has had a behavior component added to his care plan 10/28/11 by social services assistant assigned to that resident. After social service director (LCSW) assessed resident, an individualized written behavior management plan was formulated and then social service director in-serviced nursing staff on plan and placed plan in chart on 10/28/11. Resident #30 has had a behavior component added to his care plan 10/28/11 by social services assistant assigned to that resident. After socia	
N 424	1200-8-6-.04(15) Administration (15) Each nursing home shall adopt safety policies for the protection of residents from	N 424		

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N 424	Continued From page 3 accident and injury. This Rule is not met as evidenced by: Based on medical record review, review of facility reports, observation, and interview the facility failed to provide supervision to prevent one resident (#15) with behavioral problems from harming self and others; failed to provide a safe transfer for one resident (#8) which resulted in the resident sustaining a right distal femur fracture; failed to use a mechanical lift when transferring resident (#3); failed to apply a soft belt restaint properly and use an appropriate transfer for resident (#5); and failed to activate the personal alarm for resident (#14) of forty-nine residents reviewed. The facility's failure placed the residents in an environment detrimental to their health, safety and welfare. The findings included: Resident #15 was admitted to the facility on July 9, 2011, with diagnoses including Dementia, Ischemic Heart Disease, and Paroxysmal Ventricular Tachycardia. Medical record review of the admission nursing note of July 9, 2011, revealed the resident was admitted from an acute care hospital after previously residing at an Assisted Living facility. Review of the Nurse's Notes dated July 27, 2011 at 3:10 p.m., revealed, "Dr....(attending physician and facility Medical Director) in to see resident. Resident unable to respond to commands appropriately...Dr...then spoke with...(wife) re: (regarding) Res (resident) Advanced Dementia and having that Dx (diagnosis) for 10 yrs	N 424	N424 A. Resident #15 – Due to excessive wandering and unsafe behaviors in wheelchair resident sustained skin tears. Resident was one on one supervision to decrease possibility of self harm or negative interactions – which at times resulted in skin tears. One on one began October 20, 2011 with staff scheduled through nursing administration & documentation reflects this also. Staff members were relieved by other staff members for breaks & lunch. Resident went into hospital 11/3/11 for unrelated medical reasons. Psych NP was consulted and saw resident on 10/10/11 – no medication changes, monitor, chart evening behavior. Resident #8 – This resident is a 4 person lift as of 6/3/11 to help minimize the risk of further injury. CNA's involved in inappropriate transfers were counseled regarding transfer & moving of resident prior to nurse assessment during investigation on 6/2/11 by nursing management and CNA's were in-serviced regarding transfers on 6/3/11 by rehab department and nursing management. Resident #3 – CP was updated 11/2/11 to include use of gait belt or mechanical lift depending on resident cooperation. Nursing staff was in-serviced on updated care plan on 11/2/11 and 11/5/11 (Baylor) by nursing management. Rehab screen	11/08/11

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N 424	Continued From page 4 (years)...Dr...also stated Res (resident) is alert and oriented but unable to follow commands-that Res (resident) has the strength but not ability d/t (due to) advanced dementia... Dr... stated...didn't 'see' Res (resident) walking d/t advanced dementia..." Review of a quarterly assessment with a reference date of October 11, 2011, revealed the resident was assessed with minimal difficulty hearing, usually understood and usually understands others, adequate ability to see, a cognitive pattern score of 2 and unable to be assessed by the staff for Mental Status. The assessment recorded no physical behavioral symptoms directed toward others, but did record 'Other behavioral symptoms not directed toward others' occurred 4 to 6 days a week. Review of the facility Weekly Skin Reports, facility documentation, and Nurse's Notes revealed the following: August 12, 2011 - bruises to the bilateral upper extremities (Weekly Skin Report) August 19, 2011 - abrasion to left knee (Weekly Skin Report) August 25, 2011 - skin tear to right hand documented in Nurse's Notes August 31, 2011 - facility documentation for a skin tear top of the right hand September 3, 2011 - facility documentation for bumping right elbow/skin tear September 9, 2011 - left hand skin tear (Weekly Skin Report) September 21, 2011 - facility documentation for skin tear from chair rail September 25, 2011 - two facility documentation, one for "ran w/c into another resident's knees and ran w/c into another resident's w/c" and a second dated and timed the same as the first report "ran	N 424	completed 11/2/11 reflecting ability of resident to be transferred by gait belt. Resident #5's soft belt was immediately placed correctly on October 18, 2011. Nursing management assessed resident on 10/26/11 and an alarming seat belt was placed, this was care planned and in-servicing of CNA's done on 10/26/11. CNA's performing inappropriate transfer and moving resident prior to nurse assessment were counseled on 10/18/11 and in-serviced on 10/19/11 by nursing management an rehab department. Biohazard room key was moved from near the door to the nurses desk. Sign above doorknob states "See nurse for key." Key was removed from door October 18, 2011. Resident #14 – the alarm was activated on October 18, 2011. A new alarm chair pad with activation inside the box was placed on resident 11/2/11 to ensure activation. Alarm checks are done by CNA's during walking rounds routinely during daily care and a light flashes when battery is needed. The CNA's are in-serviced as new alarms are placed by nursing management. Alarms placement is tracked through QA nurse and alarms are discussed during weekly sub QA meeting. In-servicing began on 10/28/11 and all staff were in-	

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N 424	Continued From page 5 over another resident's feet" September 26, 2011 - facility documentation for a skin tear to the left forearm found when long-sleeve shirt removed to shower September 30, 2011 - a new bruise to the right upper extremity (Weekly Skin Report) October 2, 2011 - facility documentation, "rolled w/c into something on Wing 4 and ran into something and got a skin tear to right hand" October 4, 2011 - skin tear of the right dorsal hand documented in Nurse's Notes October 7, 2011 - facility documentation for skin tear of left hand/third finger October 9, 2011 - facility documentation, "bumped into (another resident) and (the other resident) got angry and poured water on him" October 14, 2011 - two skin tears right dorsal hand and bilateral upper extremities with small bruises (Weekly Skin Report) Review of the resident's Plan of Care (POC) revealed, "7/20/2011 - ADL (activities of daily living) Functional Deficit, potentially related to Nonambulatory...Intervention... primary mode of locomotion is the wheelchair (w/c)..." Further review of the POC revealed the Problem 'Activities' dated July 18, 2011, and did not include any interventions specific to the resident's constant motion with the w/c and moving throughout three of four wings of the facility. Review revealed all the current Problems on the POC included had a Target Date for the Goals moved forward to January 2012, but the Problems did not include the behavior displayed that had contributed to the resident being injured repeatedly with skin tears and negative interactions with fellow residents. Review of the August 31, 2011, Nurse's Notes revealed a 5:00 p.m., "...Spoke with wife and	N 424	serviced by 11/7/11 unless on vacation or leave and they will be in-serviced on date of return to work. All agency staff will be in-serviced prior to work. B. All residents have the potential to be adversely affected by this deficient process. Residents at risk are identified by incident reports, rehab screens, admission history, and residents with restraints. Residents with behavioral problems needing supervision to prevent self harm and negative interaction were identified by MDS assessment, behavior sheets, incident reports, and staff interviews by social service staff beginning 11/4/11 & completed 11/7/11. CP's have been reviewed and updated as needed and in-servicing of updated completed 11/7/11 by SS staff & nursing management. Residents requiring assistance with transfers was identified by nursing management per review of CP and assessment on 11/7/11 – 19 resident CP's were updated by nursing management to reflect care required/given. In-services of updates to direct care staff by nursing management was completed 11/8/11. Residents with restraints were observed on 10/19/11 by nursing management & rehab staff regarding appropriate placement and no other restraints were placed incorrectly.	

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N 424	Continued From page 6 made aware of new skin tear. Wife has concern for WC (wheelchair) safety..." Observation in the Wing I dining room from 5:45 a.m., until 6:30 a.m., on October 18, 2011, revealed resident #15 seated in a high back w/c without foot pedals or leg rest, using feet to propel around the large dining. Observation revealed seventeen residents in the dining room at 5:45 a.m., with ten of the seventeen residents asleep in their chairs. Observation of resident #15 from 5:45 a.m., until 6:30 a.m., on October 18, 2011, with the resident propelling forward and backwards at intervals, revealed the following: Bumped into a sleeping resident (#20) with the back of the w/c and resident #20 jerked their hand away from the arm of their w/c resident #15 had come into contact with and resident #20 yelled, "Get away!"; propelled w/c into the wheelchairs of residents (#25 & #30); proceeded to move from the back of the room to the front of the room, circling to the left past two tables with residents seated in their wheelchairs; then, while in a forward motion, bumped into the oxygen tank of resident #26; and bumped into the back of the w/c of resident #12 (asleep in w/c). Observation revealed there were no staff members in the dining room for the forty-five minutes when resident #15 was roaming the dining room in constant movement. Observation and interview at 6:30 a.m., on October 18, 2011, with the Licensed Practical Nurse (LPN #10) who entered the dining room upon request and observed the constant movement, bumping w/c into other residents, revealed, "He doesn't need to be in here...the Clinical Manager (CM) recently put (resident #15) on the Get Up List "	N 424	Daily observation by nurses & nursing management during care continues and in-servicing by nursing management & rehab will continue on orientation and per occurrence. Residents with alarms were checked for activation by nursing management on 10/18/11 with no other alarms not activated. Review of alarms were done on 11/7/11 by nursing management with no further action needed. CNA round sheets include checking of alarms. All other 6 biohazard doors were checked by environmental service director and keys moved & signs placed where no key pad is in place. Residents at risk are reviewed in weekly sub QA meeting with nursing management, rehab, SS staff, medical director, pharmacy consultant. Supervision to: prevent behavior issues resulting in harm to self & others, prevent inappropriate transfers resulting in harm, using transfer recommendations appropriate for residents, applying ordered appropriate restraint properly, securing biohazard rooms, and appropriate alarms in working order & activated, will be provided by nurses, nursing staff, nursing management, psych NP, therapy dept., social services, activities, administrator, MD/NP, medical director by in-servicing at monthly	

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N 424	Continued From page 7 Observation of Wing I Dining Room on October 18, 2011, from 11:55 a.m., until 12:35 p.m., revealed resident #15 seated with the back of w/c against the dining room wall to the left of the double door. Observation included approximately forty-five residents seated at ten tables eating with five staff members and three family members in the room assisting residents. Observation at 12:20 p.m., revealed resident #15 propelled the w/c (using the feet) forward approximately eight feet and rammed the w/c into the dining table where resident #14 was seated. Observation continued and the ramming motion was repeated three more times, then resident #15 retreated about four feet, paused for four minutes, and then rammed into the same dining table again. Observation revealed certified nursing assistant (CNA #12) came to the table of resident #14 and took resident #15 back against the dining room wall. Continued observation revealed the third food cart arrived at 12:30 p.m., and CNA #12 began to feed the resident. Interview at 8:00 a.m., on October 19, 2011, with the Director of Nurses (DON) and the Wing I Clinical Manager, at the Wing I nursing station, revealed the following: The "Get Up List" was developed by the CM and listed twenty-one residents to be gotten up prior to 7:00 a.m. and included eleven residents designated, " ...to be gotten up EVERY DAY!!!"; the List contained seven residents with behaviors; the CM was aware resident #15 was frequently in the dining room in the early morning hours unsupervised; and confirmed the first of three food tray carts were not delivered to the Wing I dining room before 8:15 a.m. Interview continued related to the observed "ramming of the dining table at lunch the prior day and the CM stated resident	N 424	mandatory meetings as needed by occurrence. Nursing management will do compliance rounds/ daily observation and will make referrals to therapy, social service dept. and psych NP as needed. Review of residents identified at risk will be done weekly with this team & medical director as resident need dictates. C. Each incident of unknown origin & behavior issues will be reviewed daily upon occurrence. Also incidents of unknown origin, behavior issues, restraint application/elimination and alarm application/elimination will be reviewed weekly at sub QA meetings. The administrator attends all weekly sub QA meetings unless outside facility and receives reports as appropriate. Education & training of staff regarding abuse, unknown origin incidents, Behavior Management Plans will be ongoing. Administrator will continue to be involved in in-services. D. Administrator will read and review all reports concerning potential abuse/injuries of unknown origin along with the incident report and also interview personnel having any direct knowledge of the incident to ensure that incident does not reoccur and this information will be included in the QA meeting for review and follow up.	

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N 424	Continued From page 8 #15's encounters were usually not intentional and "usually in backwards motion." Interview confirmed there was no written behavior management program in place for resident #15's behaviors and the plan was to "watch out for" the resident. During interview, the CM stated a psychological consult had been ordered by the Family Nurse Practitioner (FNP/physician extender for the Medical Director), but could not confirm if it had been completed and stated "would check." Interview with the Wing I CM at 4:20 p.m., on October 20, 2011, in the conference room, verified resident #15 had been observed by the CM on October 18, 2011, at 12:20 p.m., ramming into the dining table of resident #14. During interview, the CM stated, "...I guess the CNA (#12) I asked to stay with (resident #15) was trying to help out others until (resident #15's) meal tray came...saw him ramming and told... (CNA #12) to get (resident #15) and stay with him..." Interview continued and the CM stated a "casual attempt" was made to keep the resident under "one to one" observation Tuesday, October 18, 2011, and the resident was formally "one to one" on October 19 and 20, 2011. During interview, the CM was asked why the resident was placed on "one to one" and the CM stated, "...the resident's behaviors could place others in harm's way..." Interview in the coference room, with the Assistant Director of Nurses (ADON) on October 19, 2011, at 10:00 a.m., verified resident #15 had nine skin tears, bruises, or interactions with other residents filed in formal reports and none had a complete investigation. Interview confirmed the resident had not been care planned to prevent skin tears and the unsafe use of wheelchair.	N 424		

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N 424	Continued From page 9 Interview verified resident #15 had no behavior management program to address the unsafe behavior. Interview revealed the facility did not have a written behavior management policy or program. Interview on October 21, 2011 at 9:10 a.m., with the Nurse Practitioner (Psych Mental Health Nurse Practitioner/PMHNP) contracted for psychiatric consults on October 21, 2011, at 9:10 a.m., in the Director of Nurse's office revealed the social services staff had not formally requested a consult related to the resident and stated the primary responsibility for addressing behaviors was with the facility's Licensed Clincal Social Worker (LCSW). Interview confirmed the PMHNP had not followed up to see if the evening behaviors were being documented as was requested on October 10, 2011. Interview with the CM at 4:45 p.m., on October 20, 2011, at the Wing I nursing station, confirmed the nursing staff were not documenting the behaviors as requested on October 10, 2011, in the initial evaluation by the PMHNP. Review of the Resident Council minutes for July 2011 revealed under New Business, "Wing I resident (#22) stated, 'I keep getting bumped into all the time..." Review of a Resident Council Grievance Form initiated in response to resident #22's complaint revealed a response from the Wing I Clinical Manager, "Spoke with Res concern d/t (due to) one particular Res (#15) with dementia bumping into...asks staff to watch other res and keep ...(resident #22) away from this res. Instructed this res to call staff when...observed other res coming towards...(resident #22)" During the Group Interview, conducted with seven	N 424		

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N 424	Continued From page 10 residents, on October 25, 2011, in the Wing II dining room, the resident council interim president (resident #27) stated resident #15 continued to be a issue for the residents due to bumping fellow residents with...w/c, During the Group interview, resident #22 stated, "...my sister had to get ___ (resident #15) off (another unnamed resident)...mashing with w/c." Continued interview revealed several residents in the group interview referred to resident #15 as, 'the rammer." Interview on October 20, 2011, at 4:00 p.m., with resident #19, in the resident's room, revealed, "(Resident #15) goes so fast (resident #15) could hurt someone." Continued interview with resident #19 revealed resident #15 was "dangerous" and the resident was afraid of resident #15. Continued interview revealed the resident used a walker for ambulation and couldn't get out of resident #15's way if was too close. Interview on October 20, 2011, at 9:30 a.m., with resident #22 in the resident's room revealed, "...a couple of weeks ago" resident #15 had bumped into resident #22's walker causing the walker to hit their legs, while seated in the dining room. Review of the facility's documentation confirmed the incident had occured on September 25, 2011, and the resident had sustained no injury. Interview on October 20, 2011, at 3:30 p.m., with resident #27, in the resident's room, revealed resident #15 was named the Wild Man by resident #27. Interview continued and resident #27 stated, "The Wild Man backs into people, rams people, and hits the glass wall in the dining room...tired of (resident #15) coming into my room and them not doing anything about it...I doused him with my water pitcher and he	N 424		

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N 424	Continued From page 11 shivered..." Interview on October 20, 2011, at 4:30 p.m., with residents' #36, #37, and #38, in the dining room, confirmed resident #15 "was confused and was always rolling the wheelchair in the dining room bumping into residents." Interview further revealed they, "knew to watch for him and keep out of his way." Interview on October 20, 2011, at 4:25 p.m., with resident #40, in the resident's room, revealed resident #15 had bumped into resident #40's wheelchair from behind last week while seated at a dining room table. Continued interview revealed resident #40 had been pushed into the edge of the table, but was not injured. Continued interview revealed resident #40 was afraid of resident #15 and "watched out" to see the whereabouts of resident #15. During an extended interview with the Administrator on October 21, 2011, at 9:10 a.m., in the conference room, related to injuries of unknown origin and resident behaviors, the administrator verified signing six of the reports filed for resident #15 and stated, "I can't possibly know about all the behaviors...I knew about 2 or 3...I wasn't aware of what (resident #15) was doing with...wheelchair." During the interview, the administator verified the facility did not have a behavior management program and stated, We are working on it right now..." Resident #8 was transferred to the facility from a Hospice in another state on July 20, 2010, with diagnoses including Advanced Dementia with Psychotic Features, history of Right Shoulder Repair, Osteoarthritis, and Kyphosis.	N 424		

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N 424	Continued From page 12 Medical record review of a assessment dated April 26, 2011, revealed the resident was ninety-four years old, non-ambulatory, with functional limitations of both lower extremities. Review of the physician orders from admission to the October recapitulation orders revealed the resident was on "Comfort Measures." Review of the mobile x-rays obtained on June 2, 2011, revealed, "Conclusions: 1. Acute comminuted fracture of distal femoral metaphysis...3. Moderate diffuse osteopenia... " Review of the Physical Therapy Screening Tool dated July 21, 2010, revealed, "...has B (bilateral) plantar flexion contractures (foot drop)...Recommend lifting pt (patient) for transfers... " Interview in the conference room on October 20, 2011, at 8:30 a.m., with the Physical Therapist (PT) responsible for the July 21, 2010, screening and recommendation verified resident #8 remained a full lift from admission and the PT stated they did not know why the CNA care plan called for, "Wt. Bearing-limited," with two persons at the time the resident sustained the fracture with a transfer on June 1, 2011. Review of the resident's Plan of Care, last updated April 31, 2011, revealed, "Problem - FALLS 07/28/2010 - At risk...Nonambulatory, Requires full staff assistance with all transfers...Problem-ADL (activities of daily living)...Requires total assistance with transfers... Intervention-...Assist with transfers with assist of 1-2 at all times... " Review of the Care Plan (not dated) provided by the Wing I Clinical Nurse Manager and identified	N 424		

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N 424	Continued From page 13 as the care plan provided for the certified nursing aides (CNA) prior to June 1, 2011, revealed under the heading 'Assistance-Transfer' the boxes for two (persons) and Wt. (weight) Bearing were checked with "limited" penciled in next to Wt. Bearing. Review of the facility's Investigation/Witness Accounts Form (written statement) of one of the two CNAs (certified nursing assistant #1) performing the transfer at the time resident #8 was injured revealed, "Another CNA asked me to come into the room to assist with transferring a resident into the shower chair. As we were transferring resident into the chair we had to place resident on the floor due to slipping. Resident set with one leg under bottom and one out in front with her back resting on my legs. We called for assistance and while waiting for assistance we got resident's leg out from under her. Resident complained of pain once back in bed after shower. I advised other CNA to inform nurse to make sure resident was okay." Review of the second CNA's statement (CNA #2) revealed the resident was placed into the shower chair after a third CNA arrived to help and was put back into the bed after the shower was completed with a weight-bearing transfer performed by CNAs #1 and #2. Review of the Investigation/Witness Accounts Form completed by the CNA (#11) assisting the resident the following morning, June 2, 2011, revealed, "...This morning at breakfast when I pulled...up...complaining terribly in pain with...leg...pulled the cover up and noticed...knee very swollen...ankle area bruised...went and got...nurse on duty."	N 424		

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N 424	Continued From page 14 Interview with LPN #1 by telephone on October 19, 2011, at 2:50 p.m., revealed LPN #1 first learned of the incident involving resident #8 after 4:00 p.m., on June 1, 2011, when one of the CNAs, "...came and told me they had to...set on the floor...(resident) wasn't complaining of pain and I didn't assess any injury...I wasn't told what really happened...When I came to work the next day, I learned about the fracture...began questioning everyone and got a different story from each one. " Review of a facility investigation follow-up, completed by the Assistant Director of Nursing (ADON) on June 4, 2011, revealed, "Sent to ER (emergency room) on 6-2 c/o (complaint) RLE (right lower extremity) pain. Acute Femoral fx (fracture) noted. Redirection to CNA to have assistance when transfers..." During interview at 3:10 p.m., with the ADON on October 19, 2011, in the conference room, the ADON stated, "CNAs transferred and didn't do a good transfer...They were doing a transfer and the resident started slipping and was lowered to the ground..." Interview verified the ADON had not addressed the resident having "leg pulled out from under (him/her)" as one of the CNA's written statements revealed and had not addressed the resident being moved prior to the nurse in charge assessing the resident. Interview continued and confirmed the CNAs are instructed and repeatedly educated to have a nurse assess the resident after falls. Interview at 10:50 a.m., on October 21, 2011, by telephone with CNA #2 verified, when oriented to the facility upon hire, they were instructed not to move a resident after a fall or if the resident was lowered to the floor to have the nurse assess the	N 424		

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N 424	Continued From page 15 resident prior to moving the resident. Interview continued and confirmed on June 1, 2011, the CNAs "partly picked (the resident) up and got leg out from under..." then put into shower chair, showered and returned to bed with a partial weight-bearing transfer and did not request a nurse to assess . Review of the investigation which included a basal cause dated June 10, 2011, completed by the Wing 1 Clinical Manager revealed, "CNA's were attempting to transfer res (resident) from bed to shower chair-had to lower res to floor, during which time res right leg twisted underneath...resulting in distal femur fracture." Review of the investigation revealed Basal Cause, "improper transfer tech (technique). No use of gait belt. " Interview in the Director of Nurse's office on October 21, 2011, at 10:00 a.m., with the Wing 1 Clinical Manager and the ADON, verified the resident's Plan of Care stated one to two persons were to assist with transfers, the CNA care plan stated two persons to assist with transfers. Interview verified the care plans were not in agreement with the amount of assistance necessary to transfer and confirmed both care plans were in conflict with the recommendation from the Rehab staff for a full lift of the resident for transfers. Interview confirmed, at the time the resident sustained the fracture of the femur, an inappropriate transfer involving weight bearing was being attempted. Resident #3 was admitted to the facility on July 10, 2007, with diagnoses including Paraplegia, Brain Injury, and Seizure Disorder.	N 424		

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N 424	Continued From page 16 Medical record review of an assessment dated September 23, 2011, revealed the resident was total dependence for transfers, independent for decision making, and other behavioral symptoms occurred four to six days a week. Medical record review of the Falls Prevention Program Interventions dated March 1, 2010, and updated March 12, 2011, revealed "...one to two person transfer with mechanical lift..." Medical record review of the Interdisciplinary Plan of Care dated September 19, 2011, revealed "...At risk for Falls R/T (related to) impaired physical mobility, neurogenic disorder, and medication use...assist with transfer, assisting at level of: Total with mechanical lift and 2 or more persons...use mechanical lift for all transfers with assist of 2 or more persons..." Observation on October 20, 2011, at 8:18 a.m., in the resident's room, revealed CNA #9 and CNA #10 transferred the resident from the wheelchair to the bed with a gait belt. Interview with Registered Nurse (RN) #4 on October 20, 2011, at 9:05 a.m., in the Wing Two Nurses' Station, confirmed the resident was to be transferred with the mechanical lift and the facility failed to provide a safe transfer. Resident #5 was admitted to the facility on April 14, 2011, with diagnoses including Dementia, Unsteady Gait, Muscle Weakness and Alzheimer's Disease. Medical record review of an assessment dated August 29, 2011, revealed the resident had short and long term memory problems, required limited assistance and one person physical assist for	N 424		

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N 424	Continued From page 17 transfers, dressing, and bathing. Medical record review of the Interdisciplinary Plan of Care dated July 26, 2011, revealed "...Restraint Use: Soft Belt, potentially related to Unsteady gait...Risk Factors...falls, injury..." Medical record review of the Physician's Orders dated October 1, 2011, revealed, "...soft belt restraint while up in wheelchair D/T (due to) unsteady gait and cognitive impairment..." Review of the manufacturer's application instruction sheet for the lap belt revealed, "...lay the belt across the patient's lap...bring the strap ends with loops down over the thighs between the seat and the wheelchair skirt guard...go around the back post and cross the straps behind the patient...secure the loops on the wheelchair tilt levers...belt should be over the patient's hips at a 45-degree angle holding the hips against the back of the chair..." Further review revealed "...adverse reactions: The patient may become restless or agitated if the device is uncomfortable...severe emotional, psychological problems may occur if a patient's movement is severely limited..." Observation and interview on October 18, 2011, at 6:45 a.m., in the Wing IV dining room, with Licensed Practical Nurse (LPN) #4 revealed the resident seated in a wheelchair with a soft belt yelling loudly. Continued observation and interview revealed the right strap of the belt was between the wheelchair seat and the wheelchair skirt and the left strap of the belt was placed over the wheelchair skirt. Continued interview confirmed the soft belt restraint was not applied correctly according to the manufacturer's instructions.	N 424		

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N 424	Continued From page 18 Medical record review of the Interdisciplinary Plan of Care dated July 26, 2011, revealed, "...assist in transfer...limited assist of one person..." Medical record review of the Physical Restraint Elimination Assessment dated August 7, 2011, revealed, "...non-ambulatory... chairbound...partial weight bearing/assist of one for transfer..." Observation on October 18, 2011, at 9:50 a.m., in the resident's room, revealed Certified Nurse Aide (CNA) #6 and CNA #7 transferred the resident from the wheelchair to the toilet, by lifting the resident under the arms. Interview with CNA #6 on October 18, 2011, at 10:00 a.m., in the resident's bathroom, confirmed a gait belt was to be used when transferring residents and the CNA's had failed to use a gait belt. Interview with Occupational Therapist Registered (OTR) #1 on October 18, 2011, at 12:10 p.m., in the Wing Two Nurses' Station, confirmed a gait belt was required for all transfers but there was no written policy. Continued interview confirmed all staff were educated upon hire and periodically during employment to "always" use a gait belt during transfers. Continued interview revealed it was not appropriate to lift a resident under the arms due to the potential for injury such as shoulder/arm fracture and the facility failed to provide a safe transfer. Resident #14 was admitted to the facility on September 10, 2007, with diagnoses including Cerebrovascular Accident, Motor Vehicle	N 424		

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N 424	Continued From page 19 Accident with Traumatic Brain Injury, Convulsions, and Rosacea. Medical record review of an assessment dated October 11, 2011, revealed the resident had severely impaired cognitive skills, was totally dependent with transfers, and did not walk. Medical record review of the Fall Risk Assessment dated July 17, 2011, revealed the resident was at high risk for falls. Medical record review of the Interdisciplinary Plan of Care, reviewed on July 20, 2011, revealed "...Falls, at risk for...Use personal or pressure sensor alarms when...is in chair or bed..." Observation on October 18, 2011, at 8:50 a.m., revealed the resident seated in a wheelchair, in the dining room, with a clip alarm attached to the back of the resident's shirt. Continued observation revealed the clip alarm was connected to an alarm box attached to the back of the resident's wheelchair, and there was no indication the alarm box was activated. Observation and interview on October 18, 2011, at 8:55 a.m., with LPN #1, in the dining room, revealed LPN #1 removed the alarm box from the back of the resident's wheelchair, and confirmed the alarm box was not turned on/activated.	N 424		
N 780	1200-8-6-.06(10)(b) Basic Services (10) Social Work Services. (b) Social work services shall include psychosocial assessment, counseling, coordination of discharge planning, community liaison services, financial assistance and	N 780		

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N 780	Continued From page 20 consultation. This Rule is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide social services adequate to meet the needs of four residents (#12, #15, #27, & #30) of four residents reviewed with behaviors affecting other residents. The facility's failure to provide social services adequate to address the resident to resident behaviors placed the residents on Wing I and IV in an enviroment which was detrimental to their health, safety, and welfare. The findings included: Resident #12 was admitted to the facility on December 11, 2008, with diagnoses including: Dementia with Behaviors, Alzheimer's Dementia, affecting and a History of CVA (Cerebro-Vascular Accident). Medical record review of the facility resident assessment dated September 6, 2011, revealed resident #12 with severe cognitive impairment. Medical record review of an Interdisciplinary Plan of Care, dated December 9, 2011, and updated September 9, 2011, revealed a diagnoses of Dementia with Behaviors and Senile Delusions. Continued review revealed behavior signs or symptoms had not been addressed in the resident's care plan. Review of a facility investigation dated January 3, 2011, revealed an altercation with another	N 780	**N780** A. Resident #12 has had a behavior component added to her Care Plan 10/28/11 by social service assistant assigned to that resident. After SS director (LCSW) assessed resident, on 10/28/11 an individualized written behavior management plan was formulated, and then SS director in-serviced nursing staff on plan and placed plan in chart on 10/28/11 and also copy of plan placed in Behavior Sheets book at nurses station. Resident #15 has had a behavior component added to his care plan 10/27/11 by social services assistant assigned to that resident. After social service director (LCSW) assessed resident, on 10/27/11an individualized written behavior management plan was formulated and then social service director in-serviced nursing staff on plan and placed plan in chart on 10/28/11. One on one was already in place and continued until out to hospital for unrelated medical issues on 11/3/11. Resident #27 has had a behavior component added to his care plan 10/28/11 by social services assistant assigned to that resident. After social service director (LCSW) assessed resident, an individualized written behavior management plan was formulated and then social service	11/08/11

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N 780	Continued From page 21 resident, resulting in resident #12 being "slapped across the face...seperated residents." Review of a facility investigation dated January 17, 2011, revealed another resident, "slapped (resident #12) scratching the nose, a small amount of bleeding occurred...seperated residents...assessed for injuries." Review of a facility investigation dated March 28, 2011, revealed "resident became agitated and began clawing at CNA (Certified Nursing Assistant)." Review of a facility investigation dated May 16, 2011, revealed an altercation, witnessed by Activity Department staff, in Wing One dining room, resulted in resident #12 being sent to the ER (Emergency Room) due to multiple scratches on the face and a cut to the left eye. Review of a facility investigation dated August 23, 2011, revealed, "resident was propelling self in wheelchair...when another resident began hitting resident (#12) in the face with fists...hematoma (bruise) above left eye...seperated residents." Review of a facility investigation dated October 15, 2011, revealed, "...(resident #12) grabbed res (resident #30) by the arm and would not release...then res (#30) started hitting res (#12) on the R (right) lower jaw." Interview with the Wing One Clinical Manager (CM) confirmed resident #12 had frequently exhibited behaviors resulting in resident to resident altercations. Interview continued and the CM verified the social services staff were responsible to assess behaviors and address behaviors and confirmed behaviors were not	N 780	director in-serviced nursing staff on plan and placed plan in chart on 10/28/11. Resident #30 has had a behavior component added to his care plan 10/28/11 by social services assistant assigned to that resident. After social service director (LCSW) assessed resident, an individualized written behavior management plan was formulated and then social service director in-serviced nursing staff on plan and placed plan in chart on 10/28/11. In-servicing on behavior management policy, abuse policy, & incidents of unknown origin began on 10/28/11 and all staff were in-serviced by 11/7/11 unless on vacation or leave and they will be in-serviced on date of return to work. All agency staff will be in-serviced prior to work. B. Residents who exhibit intrusive, aggressive, reactive tendencies will be assessed by social service department by 11/7/11 and care planned after assessment on 11/7/11. In-servicing of updated interventions to direct care staff by social service staff was completed on 11/8/11. Staff on vacation or leave will be in-serviced on date of return to work. All agency staff will be in-serviced prior to work. Also, any resident upon admission who has a history of similar behaviors will be assessed by social service director and/or assistants as part of the social history	

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N 780	Continued From page 22 addressed in the resident's Interdisciplinary Plan of Care. Interview with Licensed Clinical Social Worker and Social Service Assistant, on October 20, 2011, at 11:15, in the conference room, verified resident #12 was known to exhibit "intrusive" behaviors and this frequently led to resident to resident altercations resulting in harm to resident #12. Interview continued and confirmed the resident's known behaviors had not been care planned and a behavior management program had not been established for resident #12. Interview with Psychiatric Nurse Practitioner (PMHNP) on October 21, 2011, at 9:22 a.m., in the Director of Nurse's office, confirmed resident #12 was diagnosed with Dementia with Behaviors and Senile Delusions. Interview with the PMHNP confirmed the resident had frequently exhibited behaviors resulting in resident to resident altercations and no formal behavior modification/behavior management care plan had been established for resident #12, by the Interdisciplinary Team including nursing, social services, and the PMHNP. Resident #15 was admitted to the facility on July 9, 2011, with diagnoses including Dementia, Ischemic Heart Disease, and Paroxysmal Ventricular Tachycardia. Review of the quarterly resident assessment with a reference date of October 11, 2011, revealed the resident was assessed with a cognitive pattern score of 2 and as unable to be assessed by the staff for Mental Status. The resident assessment recorded no physical behavioral symptoms directed toward others, but did record	N 780	during the admission process. The social service director or assistant assigned will assess/interview resident and direct care staff to formulate CP and/or behavior management plan within 5 days of admission. Social service director and/or assistant will notify nursing staff immediately on day of new admission or prior of potential behaviors. Copy of social history will be provided for nurses to review and place in 24 hour report to be reviewed every shift. Nursing, social service staff will be involved in individualizing plan for resident. Psych NP may be involved with MD and family consent. C. Nurses, nursing management, Social Services staff, psych NP, medical director will review Behavior Management Plan every week at sub QA meeting or if behavior escalates and needs assessment and additional interventions. New interventions in place will be in-serviced by social service staff. Progress will be assessed by behavior monitoring sheets, decreased reported incidents, direct care staff social service staff & activities staff observations, and interviews with residents and families regarding behaviors. Social service staff will assess daily those resident identified by incidents. Communication between depts. will	

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N 780	Continued From page 23 'Other behavioral symptoms not directed toward others' occurred 4 to 6 days a week. Review of the resident's Plan of Care (POC) revealed the problems did not include the behavior displayed contributing to the resident being injured repeatedly with skin tears and negative interactions with fellow residents. Review of the August 31, 2011, Nurse's Notes revealed a 5:00 p.m., entry, "...Spoke with wife and made aware of new skin tear. Wife has concern for WC (wheelchair) safety..." Observation in the Wing I dining room from 5:45 a.m., until 6:30 a.m., on October 18, 2011, revealed the resident in a high back wheelchair (w/c) without foot pedals or leg rest using feet to peddle around the large dining. Observation revealed seventeen residents in the dining room at 5:45 a.m., with ten of the seventeen residents sleeping. Observation included the resident being in forward and backwards motion at different times, was first observed in front of the floor to ceiling windows at the back part of the room, and then came into contact with six other residents' wheelchairs as follows: Bumped into a sleeping resident (#20) with the back of w/c and they jerked their hand away from the arm of their w/c that resident #15 had come into contact with and yelled, "Get away!"; then glanced off of the wheelchairs of two male residents (#25 & #30; proceeded to move to the right and to the front of the room, circling to the left past two round tables with residents seated in their wheelchairs; then, while in a forward motion, bumped into the oxygen tank of resident #26 and the back of the w/c of sleeping resident (#12). During the forty-five minutes of the observation, there were	N 780	be daily regarding prevention & intervention. Each incident of unknown origin & behavior issues will be reviewed daily upon occurrence. Also incidents of unknown origin, behavior issues, restraint application/elimination and alarm application/elimination will be reviewed weekly at sub QA meetings. The administrator attends all weekly sub QA meetings unless outside facility and receives reports as appropriate. Education & training of staff regarding abuse, unknown origin incidents, Behavior Management Plans will be ongoing. Administrator will continue to be involved in in-services. D. Administrator will read and review all reports concerning potential abuse/injuries of unknown origin along with the incident report and also interview personnel having any direct knowledge of the incident to ensure that incident does not reoccur and this information will be included in the QA meeting for review and follow up.	

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N 780	Continued From page 24 no staff members in the dining room. Observation of the Wing I dining room on October 18, 2011, from 11:55 a.m., until 12:35 p.m., revealed resident #15 with the back of w/c up against the dining room wall to the left of the double door. Observation at 12:20 p.m., revealed resident #15 peddled in a forward motion about eight feet and rammed into one of the dining tables where resident #14 was eating. Observation continued and the ramming motion was repeated three more times, then resident #15 retreated about four feet, paused for four minutes, and then rammed into the same dining table again. Observation then revealed certified nursing assistant (CNA #12) came to the table of resident #14 and took resident #15 back to the former spot. Interview with the Assistant Director of Nurses (ADON) on October 19, 2011, at 10:00 a.m., verified the resident had interactions with other residents filed in formal reports and confirmed the resident did not have the unsafe use of the wheelchair care planned. During interview, the ADON stated social services were responsible to assess behaviors and verified the resident's unsafe behavior with the w/c affecting other residents was not appropriately assessed on the October 2011 MDS and had not been care planned to develop interventions for the behavior. Interview with the Nurse Practitioner (Psych Mental Health Nurse Practitioner/PMHNP) contracted for psychiatric consults on October 21, 2011, at 9:10 a.m., in the DON's office revealed the social services staff had not formally requested a consult related to the resident and stated the primary responsibility for addressing behaviors was with the facility's Licensed Clincal	N 780		

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N 780	Continued From page 25 Social Worker (LCSW). Interview in the conference room with the LCSW at 11:15 a.m., on October 20, 2011, revealed the LCSW stated, "assisstant responsible for that resident (referrring to resident #15). Interview verified the LCSW had not been consulted related to the resident's behaviors with the w/c. Interview continued, the social services assistant joined the interview and verified after assessing the resident with behaviors in October 2011, the social services staff did not work in conjunction with the Interdisciplinary Team to develop interventions in an effort to maintain the safety of the resident and the other residents on Wing I & IV (resident #15 had been documented wandering onto Wing IV frequently). Resident #27 was admitted to the facility on October 15, 2011, with diagnoses of Schizophrenia, Anxiety, Depression, and Vascular Dementia with Delusions. Medical record review of the resident assessment dated September 27, 2011, revealed the resident was cognitively intact and had no mood or behavior indicators. Medical record review of the Nurse's Notes dated October 9, 2011, revealed, "...Res (resident #27) was in...room et (and) res (#15)...came in and... (resident #27) yelled...to get out then took...water pitcher et threw water in...(resident #15) face...left message for Social Services..." Medical record review of the Social Service Progress Notes revealed the last entry was dated September 27, 2011.	N 780		

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N 780	Continued From page 26 Interview with the Social Worker Assistant on October 24, 2011, at 8:15 a.m., on Wing One Nurses' Station, confirmed Social Services had not completed a follow up for the resident's behavior on October 9, 2011. Medical record review of the Psychiatric Note dated September 29, 2011, revealed, "...complex behaviors...fixed delusions...nursing staff to monitor resident's behaviors..." Medical record review of the Psychiatric Note dated October 14, 2011, revealed, "...risperdal (antipsychotic)...depakote (medication for Schizophrenia) for behaviors...continues to have fixed delusions...nursing staff to monitor behaviors..." Medical record review of the Interdisciplinary Plan of Care dated March 8, 2011, revealed the care plan had not been revised to reflect the resident's behaviors. Resident #30 was admitted to the facility on November 26, 2008, with diagnoses including Alzheimer's Dementia with Behaviors, Impulse Control and Parkinson's Disease. Medical record review of the resident assessment dated October 4, 2011, revealed the resident was moderately impaired for decision making and behaviors occurred four to six days a week. Medical record review of the facility documentation dated June 27, 2011, revealed, "...residents(#12 and #30) verbally arguing... (resident #30) slapped resident (#12) across face..." Medical record review of the facility	N 780		

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N 780	Continued From page 27 documentation dated October 15, 2011, revealed, "...heard altercation...resident started hitting resident on right lower jaw..." Medical record review of the Nurse's Notes dated October 15, 2011, revealed, "...resident got into an altercation...separated residents...placed in N.P. (Nurse Practitioner) book..." Medical record review of the Interdisciplinary Plan of Care dated October 7, 2011, revealed the care plan had not been revised to reflect the resident's behaviors. Medical record review of the resident's chart revealed no social service notes, nurse practitioner notes, or behavior monitor form addressing behaviors, and the facility had not referred the resident for psychiatric examination. Interview with the Wing One Clinical Manager (CM), on October 20, 2011, at 10:00 a.m., in the Wing One Nurses' Station, confirmed the resident had a history of altercations with other residents, the facility had not addressed the residents behaviors in the care plan, and had not put a behavior management plan in place. Interview with the Director of Nurses on October 24, 2011, at 8:10 a.m., in the DON's office verified the social service assistants did not have the training and expertise of the LCSW. During the interview, the DON confirmed the social services department had not developed interventions and did not have a behavior management program in place to to address the resident #12's intrusive behaviors, resident #15's unsafe behaviors with the wheelchair, and residents #27 & #30's aggressive behaviors towards other residents.	N 780		

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	TN0601	A. BUILDING _____ B. WING _____	10/24/2011

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N1102	1200-8-6-.11(2)(a)1. Records and Reports (2) Unusual events shall be reported by the facility to the Department of Health in a format designed by the Department within seven (7) business days of the date of the identification of the abuse of a patient or an unexpected occurrence of accident that results in death, life threatening or serious injury to a patient. (a) The following represent circumstances that could result in an unusual event that is an unexpected occurrence or accident resulting in death, life threatening or serious injury to a patient, not related to a natural course of the patient's illness or underlying condition. The circumstances that could result in an unusual event include, but are not limited to: 1. medication errors; This Rule is not met as evidenced by: Based on medical record review, facility investigation review, policy review, and interview the facility failed to thoroughly investigate and report to the State Agency, an injury of unknown origin for one (#12) of forty-nine residents reviewed. The facility's failure to thoroughly investigate and report to the State Agency, an injury of unknown origin placed resident #12 in an enviroment detrimental to the resident's health safety and welfare. The findings included: Resident #12 was admitted to the facility on December 11, 2008, with diagnoses including: Dementia with Behaviors, Alzheimer's Disease, and History of CVA (Cerebro-Vascular Accident). Medical record review of the resident assessment	N1102	**N1102** A. Resident #12-Discovered bruise on July 22, 2011. Clinical manager reviewed accounts July 25, 2011 given by nurse and CNA on duty during initial discover. ADON reviewed account on July 25, 2011. Reopened investigation 10/28/11. ADON re-interviewed nurses and CNA's on duty during initial discovery. Investigation was completed 11/1/11. No other action was required. No intentional injury occurred based on resident behavior and reaction to others was unchanged, no further incident of this type has recurred. Abuse coordinator reviewed all documentation on 11/1/11 of investigation and no abuse was substantiated per clinical assessment. The medical director was notified by DON on October 25, 2011. NP was notified by DON on October 28, 2011. Medical director & NP were notified of investigation completion on 11/8/11 by DON. No further orders were given. State guardian was notified 11/1/11. In-servicing on abuse policy, unknown origin, and behavior management policy began on 10/28/11 and all staff were in-serviced by 11/7/11 unless on	11/08/11

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N1102	Continued From page 29 dated September 6, 2011, revealed the resident had severe cognitive impairment and equired extensive staff assistance for transfers, mobility, and some activities of daily living. Medical record review of a nurse's note dated July 22, 2011, by Licensed Practical Nurse (LPN) #6 revealed, "10:40 p.m. My aide came to me and told me Certified Nursing Assistant (CNA) #8 found a bruise...I went to look at it...bruise to L (left) leg to the inside." Review of the facility investigation and a signed statement by CNA #8, dated July 22, 2011, revealed, "I can see on resident's (res) face (res) in pain...I saw a huge bruise on left leg inside...I notice before the bruise near the pelvic area is swollen, so I reported to my charge nurse (LPN #6)." Continued review of facility investigation and a signed statement by LPN #6 dated July 22, 2011, revealed, "My aide (CNA #8) came and told me the resident had a bruise on (res) leg at 10:30 p.m., Friday, 7-22-11. I went and pt (patient) was in bed on R (right) side and aide pulled pt leg apart and I saw a bruise on L (left) leg to inside and red in color." Review of the Weekly Skin Assessment form dated July 22, 2011, revealed a body diagram with the right leg shaded in, from the knee to the pelvis. The diagram was labeled "lg (large) bruise with edema." Medical record review of a nurse's note dated July 23, 2011, revealed,"CNA called nurse to res (resident) room after assisting res to bed. This nurse noted purple bruising and swelling from the inner R (right) thigh extending down to the calf. Also, redness warmth and swelling to the R (upper) thigh...resident will holler out and grab leg	N1102	vacation or leave and they will be in-serviced on date of return to work. All agency staff will be in-serviced prior to work. Revised abuse policy on November 6, 2011 was combining unknown injuries/accident incidents to be included in policy. No new information was added. State was notified of incident & investigation through IRS system on 11/7/11. B. All residents with incidents of unknown origin have the potential to be affected by this deficient process. Incident reports from July 22, 2011 to current were reviewed by ADON on 11/7/11 and review of 44 unknown incidents required no further action. Incidents of unknown origin are being reviewed by nursing management initially (daily as occurrence) and ADON (QA nurse) receives incident, and the investigation begins immediately, the abuse coordinator and administrator immediately receive copy of incident as notification to begin investigation. MD/NP will be notified of each incident as well as contact person (family). Medical director will be notified of any injury, during the investigation process. All agencies (DHS, state & local agencies, and law enforcement) will be notified of abuse allegations, as per facility policy. In-servicing of all staff will be done quarterly as scheduled and as an incident occurs, in-servicing will be	

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N1102	Continued From page 30 with range of motion...T/O (telephone order)/ Dr (named physician): Venous Doppler (ultrasound diagnostic test) in a.m. to R leg to R/O (rule out) DVT (Deep Vein Thrombosis). Notify MD (Medical Doctor) of results for possible X-ray order..." Review of facility investigation and a signed statement by CNA #13, dated July 23, 2011, at 9:15 p.m., revealed, "...while getting resident ready for bed noticed lg (large) bruise to rt (right) leg, went and got nurse to come look..." Continued review of facility documentation dated July 23, 2011, revealed LPN #9's statement, "...bruising & (and) swelling R (right) inner thigh, extending down to R calf. Redness, swelling and warmth noted to R upper thigh." Review of the facility policy entitled "Bradley Healthcare & Rehab Center: Resident Injuries/Accidents of Unknown Origin" (revised 4-21-08) revealed, "The facility will provide a means to monitor injuries of unknown origin as part of an on-going quality assurance program. This procedure will assist the facility to identify injuries that may be related to mistreatment, abuse or neglect, and assist in prevention of injuries reoccurring...3. The investigation consists of an assessment of the resident's condition to determine the cause of the injury by other means than abuse or neglect...6. The Administrator and the Director of Nursing must be notified immediately when there are injuries present where suspicion of abuse or neglect, or allegations of abuse exist. The Administrator/Director of Nursing will be responsible to notify appropriate regulatory and enforcement officials as required by State and Federal Law."	N1102	done by nursing management, abuse coordinator and/or department supervisor. Nurses, nursing management, QA nurse will investigate incidents thoroughly. The administrator and abuse coordinator will receive a copy of incident report with final conclusion. Other department supervisors and staff have been in-serviced on abuse policy by abuse coordinator & nursing management completed 11/7/11 and department supervisors will investigate incidents involving their departments along with abuse coordinator and administrator. Abuse policy will be followed. Abuse policy has been revised as of November 6, 2011 to reflect Resident Injuries/Accidents of Unknown Origin with no new information added & any identification of injuries related to mistreatment, abuse, or neglect will be investigated per abuse policy. C. QA nurse will investigate each incident of unknown origin immediately upon receipt. Nurses & nurse management will begin the investigation immediately upon occurrence/discovery. Based on initial investigation with administrator and abuse coordinator receiving notification of incident and MD/NP & family notification, other entities (DHS, state agencies, & local law enforcement) will be notified per	

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N1102	Continued From page 31 Review of the facility's "72 Hour Follow-Up" document by the Assistant Director of Nursing (ADON) dated July 26, 2011, revealed, "Bruising continues @ (at) this time. Bruising not noted on prior shift/rounds. Resident requires assistance with bed mobility and transfers." Continued review revealed no other examination, follow-up, or interventions had been implemented. Interview with CNA #8, by telephone, on October 21, 2011, at 11:10 a.m., confirmed CNA #8 discovered bruising and swelling to resident #12's "left thigh and pelvic area." CNA #8 stated the bruising and swelling had not been noticed earlier in the shift and was causing the resident pain. CNA #8 stated the bruising was reported to the charge nurse (LPN #6) when discovered. CNA #8 clarified the "pelvic area" as "vaginal area" to identify the specific anatomical location of the "swelling." Interview with LPN #6, by telephone, on October 21, 2011, at 1:15 p.m., revealed LPN #6 stated, "I kinda remember a bruise on the thigh ...pinkish-purple kinda...not huge...kinda difficult to see...left the resident's room and returned to nurses' station to complete incident report." Interview with Treatment Nurse #2, one of two treatment and skin care nurses (licensed practical nurses), on October 21, 2011, at 8:45 a.m., in the conference room, revealed the treatment nurses routinely did treatments and skin assessments together, frequently on the evening shift, during the hours of 7:00 p.m. to midnight. Treatment Nurse #2 stated, "I remember looking at and documenting the bruising (on resident #12) on July 22nd." Interview revealed Treatment Nurse #2 was unsure of the exact time of the assessment.	N1102	facility policy. Incident reports will be trended in QA monthly as to unknown, conclusion, & type of injury and intervention. Trending results will be a QA audit with interventions taken to decrease common incidents. Members of QA committee are: Administrator, medical director, DON, ADON, clinical managers, pharmacy consultant, activities director or representative, treatment nurse, restorative nurse, social service director or representative and any other staff requested to attend as situation dictates based on QA findings. Each incident of unknown origin & behavior issues will be reviewed daily upon occurrence. Also incidents of unknown origin, behavior issues, restraint application/elimination and alarm application/elimination will be reviewed weekly at sub QA meetings. The administrator attends all weekly sub QA meetings unless outside facility and receives reports as appropriate. Education & training of staff regarding abuse, unknown origin incidents, Behavior Management Plans will be ongoing. Administrator will continue to be involved in in-services. D. Incidents will be reviewed and discussed in the weekly meeting with	

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N1102	Continued From page 32 Review of Treatment Nurse #2's time card, provided by the facility's Pay Roll Clerk, revealed Treatment Nurse #2 had not clocked in after 2:06 p.m. on July 22, 2011, (The bruises and swelling were discovered and reported at 10:30 p.m. by CNA #8, eight hours and twenty-four minutes after Treatment Nurse #2 had clocked out for the day). Review of the Weekly Skin Assessment dated July 22, 2011, revealed the skin assessment for resident #12 had been initialed and completed by Treatment Nurse #1 on July 22, 2011. Interview with Treatment Nurse #1, on October 21, 2011 at 8:58 a.m., in the conference room, revealed, "I don't remember...if that's what I wrote, I guess that's right. I don't remember specifics..." Interview with Nurse Practitioner #1 (NP) by telephone, on October 20, 2011, at 5:48 p.m., revealed NP #1 had not been made aware of the extent of the bruising to the resident. During interview, NP #1 stated, "...had I known the bruising was that large and/or involved the pelvic area then I would have examined the resident personally, as well as insisted on a complete investigation to determine the cause of the injuries and to rule out any inappropriate contact." Interview with the Medical Director, by telephone, on October 21, 2011, at 2:25 p.m., revealed the Medical Director was not aware of resident #12's bruises discovered on July 22, 2011, and July 23, 2011. The Medical Director stated, " no I was not aware of this... and the facility needed to find out exactly what happened...due to the obvious implication of possible sexual	N1102	nursing admin., rehab department rep., pharmacy consultant, medical director, administrator, and any other appropriate staff according to nature of incident. Administrator will read and review all reports concerning potential abuse/injuries of unknown origin along with the incident report and also interview personnel having any direct knowledge of the incident to ensure that incident does not reoccur and this information will be included in the QA meeting for review and follow up.	

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N1102	Continued From page 33 misbehavior." Interview with the ADON, in the conference room, on October 20, 2011, at 12:20 p.m., confirmed bruising of unknown origin had been identified on the resident and no cause for the bruising had been determined. The ADON confirmed no follow-up examination or documentation had been completed, nor had any intervention been identified to prevent this type of injury from reoccurring. The ADON further confirmed the bruising had not been investigated or reported as an injury of unknown origin, and the facility's policy related to "Resident Injuries/ Accidents of Unknown Origin" had not been implemented. Interview with the Nursing Home Administrator (NHA), on October 21, 2011, at 8:12 a.m., in the conference room, revealed, "...was not necessarily advised of all incident reports...I don't review all incident reports...but always involved with serious injuries or abuse allegations." The Administrator confirmed the injury had not been thoroughly investigated, and a cause for the bruises had never been determined. The Administrator further confirmed the facility policy related to injuries of unknown origin had not been implemented, nor had the State Agency been notified.	N1102		